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Psychosexual health in gynecological cancer

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1. What is psychosexual health?

The literature surrounding psychosexual health and cancer patients has primarily considered the functional aspects of the disease and its treatment at the major expense of the emotional sequelae. Sexual health is defined by WHO as: "a state of physical, emotional, mental, and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence" [1].

A principle goal of WHO is to assist its member states in achieving the highest attainable standard of health care for all, including sexual and reproductive health [2]. Global statistics show that the world's female population is carrying an overwhelming burden of need in this area. Over 200 million women cannot access modern contraception, and millions of women suffer rape, domestic violence, and sexual abuse, not only in the context of wars and criminal activities, but also in their own homes [2]. Although the physical sequelae of these disasters can be treated, such as treatment for sexually transmitted infections, the emotional impact can frequently be hidden, ignored, or may not reveal its impact until many years after the event.

Any illness or traumatic life event, past or present, can lead to sexual problems in the lifetime of a woman, and gynecological cancer is no exception. It is the root cause or trigger for sexual difficulties in at least 50% of women affected [3]. In 2012, the estimated number of women living with gynecological cancers was over three million, which means that potentially 1.5 million gynecological cancer survivors could be affected by an associated sexual difficulty [4].

Within the context of gynecological cancer, many of these problems can be alleviated if recognized and acknowledged early in the cancer journey, therefore contributing dramatic improvements to a woman's overall well-being.

2. Prevalence of sexual problems in gynecological cancers

It is now estimated that half of the population of either sex will develop cancer at some time in their life. Globally, 40% — 45% of women will have a sexual problem at some stage, with the prevalence increasing with age [5]. Between 10% and 90% of women with any cancer will have sexual problems [6] and over 50% of women with gynecological cancer will have either temporary or persistent sexual difficulties [3]. As diagnosis and treatments improve, the number of women surviving cancer will increase, and survivorship issues including quality of life have become increasingly important. Sexuality is a key component of most subjective measurable quality of life indicators [7]. Sexual function and enjoyment are important components of survivorship and should not be ignored.

3. What problems are likely to be seen?

The most common sexual problems can be divided into two groups: problems of function and/or problems of desire. There is, however, a complex interplay of organic disorders with emotional and psychosocial issues, and these divisions are merely artificial. Formal definitions of female sexual dysfunction have been adopted, including the US classifications in the Diagnostic and Statistical Manual of Mental Disorders [8], although having a sexual difficulty does not constitute having a mental health disorder. Basson et al. [9] published a useful classification of the problems. Such classifications are useful for research purposes, but may often be less helpful when treating women.

The predominant functional female sexual problem is pain on sexual intercourse, or dyspareunia. Deep dyspareunia describes intracoital pelvic pain, and superficial dyspareunia is pain on vaginal entry. Either could signify organic disease, and should be appropriately investigated. If no pathology is demonstrated, and the pain persists, then an emotional cause must be considered and pursued.

Vaginismus, or involuntary spasm of the pubococcygeal and related musculature, can prevent sexual intercourse taking place. Good history taking can clarify whether there has been any penetration of the vagina, not only penile, but by fingers, sex toys, or tampons. If not, this is diagnostic of primary vaginismus, and apart from close inspection of the vulva and offer of gentle digital vaginal examination to determine the extent of the vaginismus, no further clinical investigation is warranted. Women with gynecological cancer are more likely to have secondary vaginismus caused by pain experienced from the disease or its treatment, and fear of the pain occurring during sex [10].

Loss of libido or loss of sexual interest on the other hand is a problem of desire. There are no physiological markers for loss of desire when its origins are psychogenic, with psychosocial contributions, past and present relationships, traumas, and emotional factors all inhibiting the woman's wish to be sexual. One of the key ways to determine the origins of the sexual difficulty is to ask about the sexual and emotional relationship between the woman and her partner before the cancer diagnosis. It should not be assumed that problems are all due to the

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cancer, as long-standing relationship problems may be disclosed, and need to be incorporated into any counselling.

The exception to this is the woman who suddenly becomes menopausal following cancer treatment, who had no problems with sex or desire prior to her cancer therapy. Appropriate standard therapy for her menopausal symptoms should be considered; however, the impact of a cancer diagnosis will be life changing, and drug treatment of hormonal deprivation symptoms may not be sufficient without some psychological or counselling support, or may be contraindicated as in the case of breast and endometrial cancer [11].

4. Sexual difficulties arising from symptoms and treatments for gynecological cancers

A diagnosis of gynecological cancer is overwhelming. While the instinctive professional response from clinicians is to ensure long-term survival, sexual issues are important for quality of life and should be considered in the decision-making process [12]. Sexual dysfunction is one of the most common and distressing consequences of cancer treatment [13]. Many treatments are shown to have sexual impacts, both positive and negative, and should be discussed fully with the woman pre-treatment so that she can make an autonomous decision about her care. Early offer of discussion of sexual issues in the cancer journey can lead to better sexual outcomes.

4.1. Cervical cancer

Cervical cancer is the most common gynecological cancer worldwide. Cervical cancer survivors are at risk of sexual pain disorders, no matter which modality of treatment is used. A small study of patients who underwent radical vaginal trachelectomy for early stage cervical cancer showed sexual dysfunction, including loss of libido, for up to one year following treatment; however, by 12 months, sexual activity had reached that of healthy women [14]. Following radical hysterectomy for locally advanced cervical cancer, there was no significant difference in sexual activity and enjoyment between women with benign or malignant disease; however, the cancer group had worse problems than healthy controls with body image and vaginal functioning [15]. In women with advanced cervical cancer given chemoradiotherapy, pain during intercourse was in fact reduced after treatment [16]. This may have been a result of the resolution of bleeding, discharge, and pelvic pain. However, the anxiety surrounding cancer remains for many women. Women surviving up to 15 years following cervical cancer treatment showed poorer quality of life than healthy controls, and those who had received radiotherapy were significantly more affected by sexual dysfunction than those who had surgery alone [17]. Despite this however, orgasm may be unimpaired following radiation [18]. Many additional needs were expressed by women with cervical cancer; however, sexuality and intimacy came to the fore as a predominant issue for survivorship [19].

4.2. Ovarian cancer

It has been known for some time that the physical and emotional impact of ovarian cancer can be devastating, leading to sexual as well as global quality of life issues [20]. One study has shown a prevalence of 63% for sexual difficulties among women with a diagnosis of ovarian cancer [3]. The effects of chemotherapy and surgery, combined with the anxiety about survival can have a dramatic negative effect on the woman's libido, and even women who undertake risk-reducing salpingo-oophorectomy can suffer sexual dysfunction [21]. Many of these women are totally unprepared for the devastating effects of sudden menopause, with hot flushes, vaginal dryness, and loss of libido replacing a previously healthy sex life. This could be helped by more realistic counselling before the procedure, and increased postoperative emotional support.

4.3. Endometrial cancer

One study has shown that women who had surgery for endometrial cancer had no differences in their own sexual experience postoperatively, but compared with healthy controls, they had more sexual difficulties overall [22]. Women with Lynch syndrome who opt for preventive surgery tend to be happy overall with the surgery, but are often unprepared for the physical adverse effects of menopause [23]. In contrast, Moldovan et al. [24] has reported that, despite sometimes debilitating menopausal symptoms, there were no significant sexual difficulties associated with the procedure.

4.4. Vulvar cancer

Vulvectomy is a common treatment for vulvar malignancy. This is increasingly affecting younger women, who are HIV positive. Women with vulvar cancer can have many years of difficulties with sex due to often distressing vulvar symptoms and bleeding. Following treatment they still suffer severe dyspareunia and body image distortion due to the effects of treatment. Although a recent study showed no differences in psychosocial and sexual functioning before and after vulvectomy, it was acknowledged that women with vulvar malignancy have a high risk for sexual problems compared with healthy controls [25]. Factors associated with postoperative sexual difficulties are increased age, poor overall physical and mental health well-being, and extent of the surgical excision [25]. This often elderly group of patients is usually neglected from the psychosexual point of view.

5. Ethnic groups

The majority of the literature related to sexuality and cancer stems from high-resource countries. Although most of these studies encompass all women, there is a lack of good published evidence on the treatment of the sexual sequelae of cancer in relation to ethnic minority groups, within a majority culture [26]. Furthermore, data from low- and middle-income countries are scant. Much of the literature focuses on sexual distress and activity in relation to HIV and AIDS which, of course, is a global priority; however, this focus on infection transmission should not take away from the emotional needs of the woman who suffers from gynecological cancer. Sexuality research around the globe must be perceived and researched in terms of cultural, spiritual, ethnic, and religious contexts.

6. Treatment strategies for sexual problems

6.1. Physical

Sexual problems in women with gynecological cancer may be associated with adverse effects of surgical, hormonal, and chemical treatments, as well as by the cancer itself. Fortunately, emotional, sexual, and quality of life outcomes improve as less morbid, more minimally invasive surgical treatments for gynecological cancers develop [12].

Chemotherapy-induced ovarian failure in cancer patients is associated with all the possible symptoms of a sudden menopause, combined with the emotional impact not only of the cancer, but loss of physical well-being and fertility all at the same time.

Vaginal dryness can be a major problem to those women who wish to have sex [27], and appropriate vaginal moisturizers and lubricants can help. The issue of vaginal estrogen is still debated, but should be discussed with the patient, weighing up the risk — benefit ratio for each individual. Vaginal estrogen will, in most cases, alleviate the dryness, but there may be concerns about using hormones, especially in relation to breast cancer where the evidence is unclear. The scientific data, however, support the safety of low dose vaginal estrogen therapy [28]. It is not well understood that following a few weeks of vaginal estrogen, the vagina thickens and cornifies and estrogen is not absorbed as a result.

Newer treatments such as selective estrogen receptor modulators have been used in place of vaginal estrogen in women without cancer [29], and may prove good alternatives in the future [30]. There are non-hormonal vaginal moisturizers and lubricants to make sexual intercourse more comfortable. Unfortunately, some commercial sexual lubricants can be hyperosmolar and could cause epithelial disruption, facilitating HIV transmission [31]. Simple lubricants such as olive oil or liquid glycerin have been used successfully in interventions to alleviate pain on intercourse due to vaginal dryness, combining their use with physiotherapy and psychosexual counselling.

Treatments with pelvic external beam radiotherapy and/or with brachytherapy may cause vaginal shortening, tightening, and lack of pliability. The use of vaginal dilators to overcome these complications is widespread, despite lack of conclusive evidence, either for or against, either with or without a coating of estrogen cream [32]. Unsurprisingly, the intrusion of inserting a plastic (or sometimes glass) tube into a tender vagina after treatment is a task that may carry a deep psychological and emotional impact [33], and will have resultant poor compliance. Radiation oncologists agree that information about dilator use should be given before treatment [34], and that sufficient patient information and support are essential to improve compliance. Sensitivity to emotions and women's views and personal values in relation to sexuality are essential supports to encouraging dilator use [35].

6.2. Emotional

Any of the above problems cannot fail to have an emotional impact on the woman and on her partner. Many sexual difficulties are automatically blamed on the organic disruption caused by cancer and its treatments; however, once any clearly indicated treatments have been given, in a sizable proportion of cases, the sexual difficulty will remain unresolved.

Many sexual difficulties are psychogenic, and no amount of skilled clinical treatments will help if not linked closely to appropriate counselling, psychological, or psychosexual therapy. This form of intervention will enable the woman to expose and reflect on her sexual difficulties, in the context of her life and relationship not only since the cancer, but beforehand. This is often a time when past problems, such as childhood abuse, or problems with her current partner will surface. Some partners are disgusted by the physical impacts of cancer, and the relationship will suffer. On the other hand, some partners become more supportive and the cancer leads to stronger relationships [36].

6.3. Psychosexual interventions

Classic psychosexual therapy, using brief, focused psychotherapeutic techniques is the mainstay of treatment. It can be used with an individual or a couple, of any sexual orientation or cultural or religious background. This is a way of listening reflectively to the patient, so that they can gain their own insights into their sexual problem. The issue of genital examination is considered if relevant, as it enables the woman to connect with her genital area, and may trigger deep-seated thoughts or anxieties that the woman had blocked emotionally. This, of course, is a technique used only by clinicians who are qualified to examine the patient [37].

Clinical psychologists and counsellors trained in psychosexual work also treat women with sexual problems. Globally, because the availability of trained personnel differs, many simple innovative treatment interventions have been tried. A brief intervention using a well-accepted treatment, cognitive behavioral therapy (CBT), combined with sexual health education had positive results on patients who had risk-reducing salpingo-oophorectomy [21].

Psychosexual interventions work [38], and like all psychodynamic interventions only require a trained counsellor and a means of allowing access to the patient. The internet has enabled access to health care for many people around the world who are not able to travel long and difficult land journeys to direct provision of health care. An online intervention with a professional moderator has proven acceptable to gynecological cancer patients with a sexual difficulty [39], and another internet-based sexual difficulties intervention with counselling sessions proved more successful in improving sexuality issues than without a counsellor; however, there was no difference between the two groups in relation to emotional distress and quality of life [40]. Elsewhere, telephone interventions are being used, also with some success; however, it is clear that the knowledge, skills, and training of the health professional providing the intervention are relevant to the patient outcome.

Multidisciplinary care should form the backbone of treatment of sexual difficulties in women with gynecological cancer, incorporating physical, psychoeducational, and psychosexual input. Team discussions, including clinicians, psychosexual therapists, and physiotherapists are well within the capabilities of many cancer centers, remembering that the patient and her partner are the focal point and should always be consulted.

7. Communication

It is impossible to diagnose and treat a sexual problem if one does not acknowledge that it exists. Many studies in the past have identified lack of willingness of doctors and nurses to discuss sex, but sadly recent research has shown that not much has changed. For instance, in a cohort sample of 1154 US obstetrician — gynecologists, 60% did not ask patients about sexual problems [41]. Too often clinicians make value judgements about their patients including whether sexuality is an important part of their lives. Such assumptions may include biases about age, appearance, sexual preferences, and marital status of people who have sex.

People with cancer and their partners have unmet sexual information and support needs [42], often due to the unwillingness of healthcare professionals to discuss sexual issues, even though they recognize it may be important to the patient.

There are many barriers to talking about sex, affecting both the patient and the clinician, such as cultural background, and age and gender discrepancies between doctor and patient. There may be simple barriers, such as lack of privacy in a consultation, as often cancer patients are accompanied by family or close friends. Patients often state that they feel it is trivial to take up the doctor's time with non-life-threatening issues such as sex.

Clinicians often cite lack of training as a reason that they are uncomfortable talking about sex and poor provision of this training has been noted [13]. Different models of communication skills training have been used and those undertaking the training have shown greater empathy and were more inclined to use open questions [43]. This technique of speaking to the patient in an open rather than interrogative manner can easily facilitate discussion of intimate issues.

An even greater challenge in communication is the recognition that individuals are sexual beings up to the end of life. To some women in the palliative phase, sexual touch and closeness to their partner is of vital importance. Sadly this is rarely recognized and addressed by palliative care physicians [44].

8. Sexuality

It is important to remember that a minority of the female population identifies as lesbian, and that about 8% of the population is bisexual. While this should make no difference to the quality of sexual health care they receive, lesbians and bisexuals find it difficult to disclose their sexuality to clinicians, often inhibited by their cultural or religious background, and fears of facing discrimination [45]. If the clinician asks the patient at the outset if they have a sexual partner, and whether the partner is male or female, it will greatly enhance the quality of the doctor — patient interaction. Lesbian partners in particular can be

very supportive during the cancer journey, and should be given the opportunity to be present if the patient wishes.

9. Training

Despite the recognized need for treatment of sexual problems in menopause and gynecological cancer, there is poor provision of specialist training to ensure that this important area of service provision is met [46]. Undergraduate teaching is important, but it is only by recognizing psychosexual medicine in formal gynecology or oncology training, as a compulsory requirement of the course, that this situation will begin to be addressed.

Innovative online programs [47] can make a major impact on global training opportunities and give trainees around the world an opportunity to gain some skills and insight into treating sexual difficulties in a nonjudgmental way.

10. Psychosexual health care is a human right

Owing to the global prevalence of sexual problems associated with gynecological cancer, it should be within every gynecologist's or oncologist's duty of care to the patient to be aware of and have some understanding of how to diagnose and facilitate treatment for sexual problems in a nonjudgmental manner. This is true holistic medicine, recognizing not only the cancer, but the woman behind the symptoms, and requires awareness of the emotional, social, and relationship aspects of the patient's life. The ability of any person to enjoy a sexual life free of coercion, shame, disease, or pain in a consensual manner is a fundamental element of the human rights of women, and should be an unequivocally accepted as part of her gynecological cancer care.

To make a difference, even in the absence of expensive and sophisticated cancer treatments, just acknowledging, listening, and offering support to the woman with sexual difficulties related to cancer will ultimately have a major benefit to her quality of life.

Conflict of interest

The author has no conflict of interest.

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